STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: U1				
		HAL068003	B. WING		02/2	3/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VILLINES	S REST HOME		RO, NC 272			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	done by Bob Getch	Biennial Construction Survey ell on February 23, 2016.				
	Aged serving 8 am December 1, 1964. built a nine bed add present 17 resident meet the 1971 and 2005 Rules for the Homes, and, the 19	st licensed as a Home for the bulatory residents on In the early 1970's the facility dition increasing capacity to the is. Therefore the facility must the applicable portions of the Licensing of Adult Care 267 North Carolina State revisions, for Group D-2				
	Deficiencies were r plan of correction.	noted which will require a new				
C 164	Housekeeping and	Furnishings-Clean, Repaired	C 164			
	FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chronic (3) have furniture of	06 HOUSEKEEPING AND				
		et as evidenced by: vation, the resident furnishings ther areas were not maintained				
	loose/missing on th	furniture with handles le drawers. s furniture with handles				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
	LIAL OCCOOR		D. WING				
HAL068003			B. WING		02/2	3/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VILLINE	S REST HOME		OUEEN ST RO, NC 272				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 164	loose/missing on th c) Bedroom 10 has loose/missing on th d) Bedroom 8 has doors	e drawers. s furniture with handles e drawers. a wardrobe missing one of the furniture with handles	C 164				
C 183	Fire Extinguishers		C 183				
	(a) At least one five A-B-C type fire exting 2,500 square feet of (b) One five pound	08 FIRE EXTINGUISHERS e pound or larger (net charge) nguisher is required for each of floor area or fraction thereof. or larger (net charge) A-B-C uired in the kitchen and, where					
	protection equipme the facility safe. The	vation, the building fire nt was not maintained to keep is would affect all residents by ection equipment operable for					
		s on the fire extinguishers e monthly inspections are not er NFPA 10					
C 185	Fire Safety-Rehear	sals on Each Shift	C 185				
	quarterly on each s						

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STATE FORM 6899 IZFU21 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
HAL068003		B. WING		02/23/2016		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VILLINES	REST HOME		QUEEN ST			
(VA) ID	CLIMMADV CTA	TEMENT OF DEFICIENCIES	RO, NC 272	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 185	Continued From pa	ge 2	C 185			
	and copies furnishes social services anni include the date and shift, staff members description of what (f) This Rule shall a facilities. This Rule is not me 1. Based on observer not recorded opersonnel to be inaccessort residents fro emergency.	earsals shall be maintained and to the county department of cually. The records shall dime of the rehearsals, the spresent, and a short the rehearsal involved. Apply to new and existing set as evidenced by: vation, the fire drill reports correctly. This could cause dequately trained to safely me the building during an				
	shift, but not on 3rd no 3rd shift on the c recorded. Revise the	rills were held on 1st and 2nd shift. Furthermore, there is checksheet where the drills are ne fire drill sheet so all 3 shifts recorded when performed				
C 189	Building Equipment	Maintained Safe, Operating	C 189			
	mechanical, and plu care home shall be operating condition. (k) This Rule shall facilities with the ex	11 OTHER d all fire safety, electrical, umbing equipment in an adult maintained in a safe and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		HAL068003	B. WING		02/2	23/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VILLINES	S REST HOME		T QUEEN ST			
			RO, NC 272		TION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
C 189	Continued From pa	ge 3	C 189			
	maintained in a safe the fire-resistance r	ation, the building was not e manner by not maintaining ating of building components. I residents by not containing ne room or smoke				
	Findings include: a. The closet ceiling in bedroom 9 has an unprotected penetration by CATV. b. The 1-hour fire resistance rated basement ceiling has unprotected penetrations by CATV cable. c. The gas-fired equipment room in the basement storage room has an unprotected gas line penetration in the wall, and CATV cable penetreations in the walls and ceiling, d. The Med room has an unprotected ceiling penetration, and a gap at the light fixture. e. The office has an unprotected penetration in the ceiling by cables,					
	conformance with through penetration	openings are not in ne requirement to use a fire stop system that has rdance with ASTM E-814.				
	protection equipme the facility safe. Th the equipment failed	vation, the building fire nt was not maintained to keep is would affect all residents if d to contain smoke and fire in compartment of origin.				
	Room has no radia	g vent in the front of the Living tion damper vation, the building plumbing				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
HAL068003		B. WING		02/23/2016		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VILLINES	S REST HOME		QUEEN ST RO, NC 272			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
C 189	by not providing vac affect all residents is water into the potals. Findings include: Vacuum breakers a hose in the following a) 11/12 shared bat b) Right front hall bat c) Left front hall bat 4. Based on observati equipment was not could expose reside Findings include: Toilets are coming I following locations: a) Room 5 bathroo b) Right front hall bath 5. Based on observati were not maintained that did not close con Findings include: The following doors a) Fire door at end and latch, (repaired b) Laundry Room e loose	maintained in a safe manner cum breakers. This would by potentially siphoning waste ble water system. The needed on the tub spray glocations: the bath of the sath of the second of the	C 189	DEFICIENCY)		

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